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NetworkNews

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Provided as a service to our Provider and Office Manager Community
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CMS Expectations for Addressing the Opioid Epidemic "Part D"

In addressing the opioid epidemic, the Centers for Medicare and Medicaid Services (CMS) has new expectations for Medicare Part D plans. The most significant change is that starting **January 1, 2019**, CMS expects all Part D plans to implement a pharmacy hard safety edit. The edit, specifically is a claim reject that will limit initial opioid prescription fills for the treatment of acute pain to no more than a seven (7) day supply in opioid naïve patients.[1] Paramount will define an opioid naïve patient as one with no opioids in the previous 90 days.

CMS also expects Part D plans to implement what's called, an "opioid care coordination edit" at 90 morphine milligram equivalents (MME) per day. This pharmacy reject would trigger when a plan member's cumulative MME per day across their opioid prescriptions reaches or exceeds 90 MME. CMS guides plans to instruct the pharmacist at the network pharmacy to consult with the prescriber, document the discussion, and if the prescriber confirms intent, use an override code that specifically states that the prescriber has been consulted.[1]

Please read the referenced article below, including important information about Drug Management Programs.

1. Centers for Medicare & Medicaid Services . A Prescriber's Guide to the New Medicare Part D Opioid Overutilization Policies for 2019.cms.gov.https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE18016.pdf. Published November 1, 2018.

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Prescription Drug Changes for 2019

The Pharmacy and Therapeutics Working Group, a subgroup of the Medical Advisory Council at Paramount, has reviewed and approved changes to the Preferred Brand Drug List and 2019 Formularies for Commercial and Individual Marketplace benefits. These new lists are always available on our website at: www.paramounthealthcare.com/preferred-drug-lists.

How do Commercial Pharmacy Benefits work?

Visit the Paramount website to access an online version of the 2019 Commercial Open formulary Preferred Brand Drug List; access the 2019 Commercial Select and Commercial Advanced Select closed formularies; and learn more about our copay tiers, prior authorization and step therapy requirements, and other coverage limitations. This information is updated on the website yearly and when changes are made, as decided by Paramount's Pharmacy & Therapeutics Working Group throughout the year.

How are drugs selected for Marketplace Exchanges?

Marketplace coverage must maintain compliance with Essential Health Benefit coverage benchmarks, as determined by each state yearly. Our Pharmacy and Therapeutics Working Group also reviews changes throughout the year. Paramount has a growing number of participants who use our Marketplace formulary. Details of coverage for these members is available on our website, along with helpful tools, such as prior authorization forms and criteria. The formulary is updated on the site monthly and when changes are approved.

Who creates the Paramount Advantage Preferred Drug List?

The preferred drug list for Paramount's Ohio Managed Medicaid product is determined through a consensus-based process with the State of Ohio's Fee-for-Service formulary and with the four other Managed Care Plans' preferred drug lists. Paramount's Pharmacy and Therapeutics Working Group regularly reviews and approves changes, as well as approves utilization management (UM) limits and criteria. A new formulary list with associated UM limits is posted to the website quarterly and when changes are made.

Stay Up To Date with Drug Coverage Information

Prescription drug program information and bulletins, do you know where to look?

Announcements, change notices, and essential news for the care of your patients is frequently posted on our provider website. Today you can find information about drug list changes for Paramount Commercial, Paramount Exchange, and Paramount Advantage benefits. We also provide links to formulary listings, coverage limitations, forms and other current news. These links and announcements are designed to help serve you and your needs. Bookmark our announcements page today!
www.paramounthealthcare.com/provnews

Questions? Need a Full Preferred Drug List?

Please contact Paramount Provider Inquiry at 1-888-891-2564 with questions about your patients' prescription benefits.

Visit the Prescription Drug Program page at www.paramounthealthcare.com/providers-prescription-drug-benefits today!

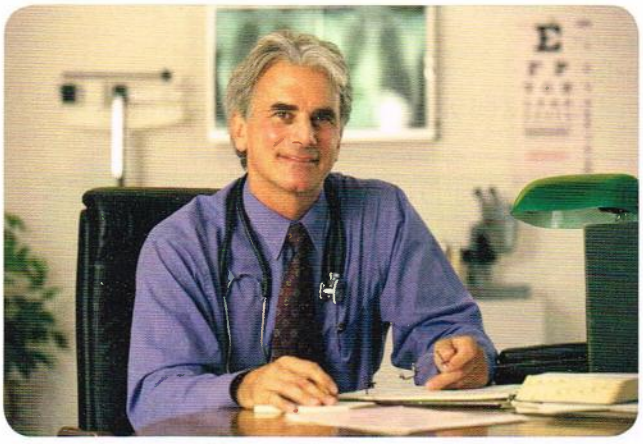
Mammogram and Cervical Cancer Screenings for Patients

Talking with your patients today could help them defend against cancer tomorrow. Remind your patients that these screenings can find cancers early, when they may be easier to treat. Let your patients know:

- Parmount recommends that women ages 40 and older have a mammogram every year.
- Paramount recommends that cervical cancer screenings, such as Pap test, be conducted every 3 years for women ages 21 to 65. At age 30 women can instead have a Pap test done once every 5 years along with a human papillomavirus (HPV) test.

The goal of these screenings is to prevent morbidity and mortality from breast and cervical cancer. Talk with your patients about the importance of these screenings and remind them how often they should be screened.

Safeguard In Utilization



Utilization Management (UM) decision making is based only on appropriateness of care and the existence of coverage. Utilization management staff and associate medical/clinical directors are not financially, or otherwise, paid to encourage underutilization and/or denials of coverage or care. In fact, Paramount monitors and analyzes monthly reports for patterns of underutilization and takes action to address any identified problems. Please note, nursing staff cannot deny services - denials can be made only by board certified, locally participating physicians, or pharmacists, when denials are for pharmacy services.

Well Visits

Thank you for the care you provide our mutual members! Please help us to improve this care by providing **Yearly Well Visits**. Children should have exams **at birth**, within ***3-5 days; by 1, 2, 4, 6, 9, 12, 15, months (at least 6 well visits by 15 months); and by 18, 24 & 30 months of age.** Then **everyone** should have **a yearly well visit**.

Please use the Paramount Provider Portal: **www.myparamount.org** or call Paramount Provider Inquiry: 1-888-891-2564 to obtain Paramount member insurance card information when a newborn member or any of our members present to office appointments without their insurance information.

When scheduling office appointments for members, please consider the following:

- Consider every visit as an opportunity for a **Yearly Well Visit** or a **Vaccine Visit** if needed.
- Review the date of the last well visit. If it is still needed, please educate members on the importance of preventive care, **schedule extra time** to provide a **well visit with a sick visit**, or schedule an additional well visit appointment.
- During the office discharge process, please try to schedule the next well visit that is due or the **next 2- 3 well visits for members before 15 months of age (at least 6 are needed by 15 months)**. This approach may help members stay on schedule and remember their well visits.
- Please send an appointment reminder with date and time highlighted when member is discharged.
- Send reminder letters or call members that are due for their well visits, **even when members have not been seen by your office.** These members either chose or were assigned to your practice.
- Call members to remind them about their scheduled visit a few days prior.
- Collaborate with your EHR vendor to incorporate **pop-up alerts** to signal when well visits, immunizations and other preventive services are due.

If billing a "sick visit" on the same day as a Yearly Well Visit: please bill the appropriate Evaluation & Management Code i.e. (99201-99215) with modifier-25.

Paramount allows a sick visit and a well visit on the same day but will not reimburse for two new visits on the same date of service. For example, if a new patient is seen and both a well visit and a sick visit are appropriately received, only one service is a new patient visit and the other is an established visit. As long as the provider's documentation supports services for a well visit and a sick visit (no overlapping documentation components) then separate reimbursement is both warranted and supported.

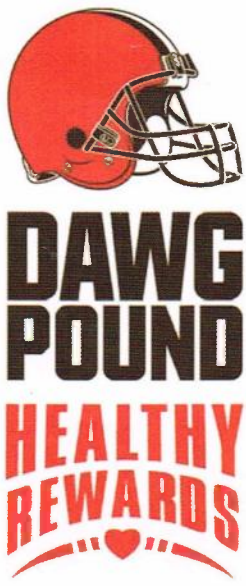
Please refer to the Recommendations for Preventive Pediatric Health Care 2017 periodicity schedule by Bright Futures/American Academy of Pediatrics for schedule details: **https://www.aap.org/en-us/documents/periodicity_schedule.pdf**

Healthy Rewards Program

Paramount Advantage continues to team up with our Ohio NFL teams to offer our Healthy Rewards program. This program rewards members for having their yearly wellness checkup/routine annual physical. Healthy Rewards is offered to eligible* Paramount Advantage members 12 months and older who register (online or through the mail), and have a yearly wellness checkup/routine annual physical in 2019.

Members Can Follow These Steps

1. Call their provider to schedule a yearly wellness checkup/routine annual physical.
2. Go to their provider and have their wellness checkup.
3. Sign up for Healthy Rewards at www.ParamountAdvantage.org or call **1-800-462-3589** (TTY: **1-888-740-5670**). That's it! They're entered to win.



What Dawg Pound Prizes Could Members Win?

Those who register will be entered into monthly drawings to win great prizes from the Cleveland Browns, such as:

- A trip to a Browns away game
- Home game suite experience
- Field day experience
- Sideline experience
- Autographed Browns jersey
- Home game tickets
- VIP training camp experience
- And more

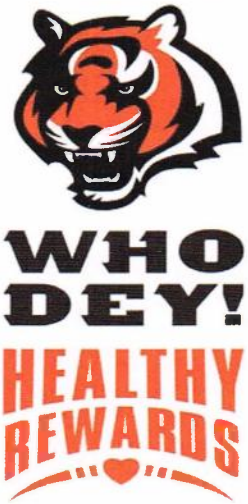
Members can enter to win Dawg Pound Healthy Rewards prizes by following the instructions and registering online at: www.ParamountAdvantage.org/Browns.

*To win, patients must be members of Paramount Advantage and 12 months of age or older at the time of the wellness checkup and when the prize is awarded.

*Due to NFL franchise marketing rules, only Paramount Advantage members in the following counties are eligible:

Allen	Fairfield	Jefferson	Morgan	Seneca
Ashland	Fayette	Knox	Morrow	Shelby
Ashtabula	Franklin	Lake	Muskingum	Stark
Athens	Fulton	Lawrence	Noble	Summit
Auglaize	Gallia	Licking	Ottawa	Trumbull
Belmont	Geauga	Logan	Paulding	Tuscarawas
Carroll	Guernsey	Lorain	Perry	Union
Champaign	Hancock	Lucas	Pickaway	Van Wert
Columbiana	Hardin	Madison	Pike	Vinton
Coshocton	Harrison	Mahoning	Portage	Washington
Crawford	Henry	Marion	Putnam	Wayne
Cuyahoga	Hocking	Medina	Richland	Williams
Defiance	Holmes	Meigs	Ross	Wood
Delaware	Huron	Mercer	Sandusky	Wyandot
Erie	Jackson	Monroe	Scioto	

Members in other Ohio counties are eligible for another program. Please see below for more details.



What Who Dey! Prizes Could Members Win?

Those who register will be entered into monthly drawings to win great prizes from the Cincinnati Bengals, such as:

- Home game tickets including $20 in "Bengal Bucks"
- Field Day event at Paul Brown Stadium
- Sideline experience
- Autographed Bengals football
- VIP training camp experience
- And more

Members can enter to win Who Dey! Healthy Rewards prizes by following the instructions and registering online at: www.ParamountAdvantage.org/Bengals.

*To win, patients must be members of Paramount Advantage and 12 months of age or older at the time of the wellness checkup and when the prize is awarded.

*Due to NFL franchise marketing rules, only Paramount Advantage members in the following counties are eligible:

Adams	Greene
Brown	Hamilton
Butler	Highland
Clark	Miami
Clermont	Montgomery
Clinton	Preble
Darke	Warren

Members in other Ohio counties are eligible for another program. Please see above for more details.

Paramount HEDIS® Results

The table below is not a complete representation of our Healthcare Effectiveness Data and Information Set (HEDIS®) measures, instead it shows some of the important data reported from this year's annual review compared to 2017 data.

We are constantly working to improve our rates and continue to ask for your assistance in providing better care and service for our members. For more information, or if you have questions, please contact phcquality@promedica.org or your Provider Relations Representative.

⇓⇑ ? Denote Statistically Significant Change ↓↑ ? Denote Change/Difference, Not Significant	Commercial HMO			Medicaid			Medicare		
	2018	vs 2017	vs Natl Avg	2018	vs 2017	vs Natl Avg	2018	vs 2017	vs Natl Avg
Immunizations									
Childhood Immunizations ? Combo #2	88.08%	⇑	↑	62.77%	↓	↓			
Childhood Immunizations ? Combo #3	87.35%	⇑	↑	58.39%	↑	↓			
Childhood Immunizations ? Combo #10	62.29%	⇑	↑	26.76%	↑	↓			
Adolescent Immunizations ? Combo #1	88.81%	⇑	↑	74.45%	⇑	↓			
Child Well Care									
Weight in Kids?BMI Percentile	84.43%	⇑	↑	70.56%	⇑	↓			
Weight in Kids?Nutrition Counseling	75.67%	↑	↑	54.74%	↓	↓			
Weight in Kids?Activity Counseling	74.94%	⇑	↑	51.09%	↑	↓			
Medication Management									
Medication Reconciliation Post-Discharge							79.08%	⇑	↑
Adult Well Care									
Adult BMI Assessment	94.17%	↑	↑	86.13%	⇑	↑	98.30%	↑	↑
Colorectal Cancer Screening	64.23%	↑	↑				75.18%	↑	↓
Adult and Child Access and Utilization									
6+ Well-Child Visits in the First 15 Months of Life	87.44%	↑	↑	58.64%	↑	↓			
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life	81.73%	↓	↑	69.34%	↑	↓			
Adolescent Well Care	50.64%	↓	↑	45.74%	↑	↓			
Adults' Access to Preventive/Ambulatory Health	95.77%	↓	↑	74.76%	⇑	↓	97.68%	↑	↑
Children and Adolescents' Access to Primary Care 12-24 Months	99.02%	↓	↑	94.20%	⇑	↓			
Children and Adolescents' Access to Primary Care 25 Months - 6 yrs of Age	94.41%	⇓	↑	85.36%	↑	↓			
Children and Adolescents' Access to Primary Care 7 - 11 yrs of age	94.29%	↓	↑	89.13%	↑	↓			
Children and Adolescents' Access to Primary Care 12 to 19 yrs of age	93.13%	↑	↑	88.66%	↑	↑			
Respiratory Health									
Asthma Medication ? 75% Compliance	50.39%	↓	↑	39.78%	⇑	↑			
Asthma Medication Ratio	66.00%	↓	↓	49.03%	↓	↓			
COPD? Systemic Corticosteroid	41.94%	⇓	↓	77.15%	↑	↑	77.82%	↑	↑
COPD? Bronchodilator	45.16%	⇓	↓	86.02%	↑	↑	81.45%	⇑	↑
CardiovascularHealth									
Controlling High Blood Pressure	71.28%	↓	↑	61.56%	↑	↑	84.18%	↑	↑
Statin Therapy in Persons with CVD	70.60%	↓	↓	80.43%	↑	↑	81.07%	↑	↑
Diabetes Care									
HbA1c Control < 8%	65.21%	↑	↑	49.39%	↑	↑	72.51%	↓	↑
Blood Pressure Control <140/90	73.72%	↓	↑	64.96%	↓	↑	77.37%	↓	↑
HbA1c Testing	91.24%	↑	↓	83.94%	↑	↓	91.73%	⇓	↓
Eye Exam (Retinal)	63.99%	↓	↑	52.55%	↓	↓	75.18%	↓	↑
Mental/BehavioralHealth									
Treatment for Alcohol/Drug Dependency (Engagement)	14.77%	↓	↑	16.38%	↑	↑	5.51%	↑	↑
Following Kids on ADHD Drugs: Initial	34.75%	↓	↓	58.63%	↑	↑			
Following Kids on ADHD Drugs: Continued	41.18%	↓	↓	69.11%	↓	↑			
Musculoskeletal Care									
Osteoporosis Management							34.43%	↓	↓

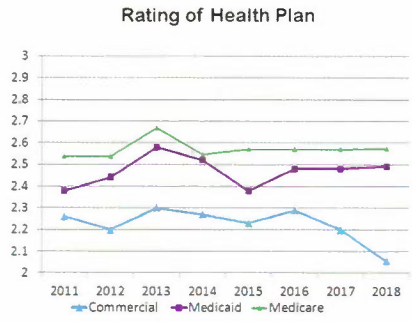
*HEDIS® is a registered trademarks of the NCQA.

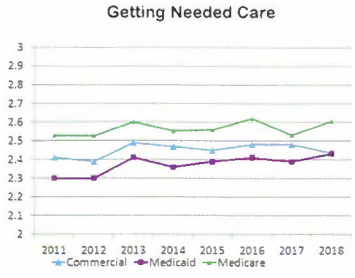
Paramount Member Satisfaction Results

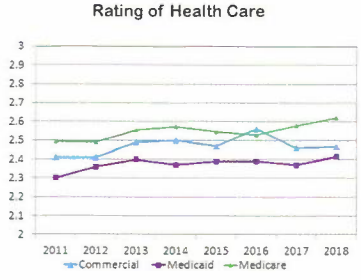
Every year, Paramount measures members' satisfaction with the quality of their care and services. Consumer Assessment of Healthcare Providers and Systems (CAHPS®) surveys are conducted as part of our Healthcare Effectiveness Data and Information Set (HEDIS®) review. These surveys are important because they help us understand how we can provide better care and service to our members.

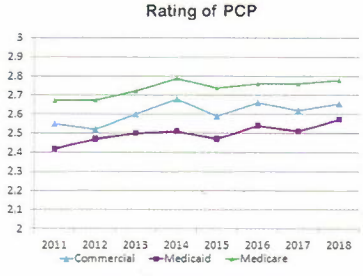
- Elite (Medicare) members are generally more satisfied with the quality of their care and services than other members in other products.

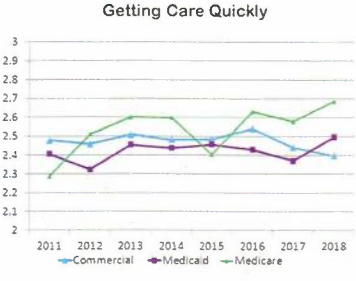
- Members in all Paramount products rated the overall quality of their health care high, for which we thank **YOU**- our providers!

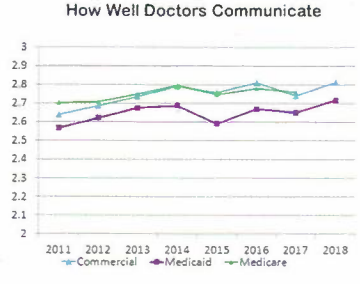








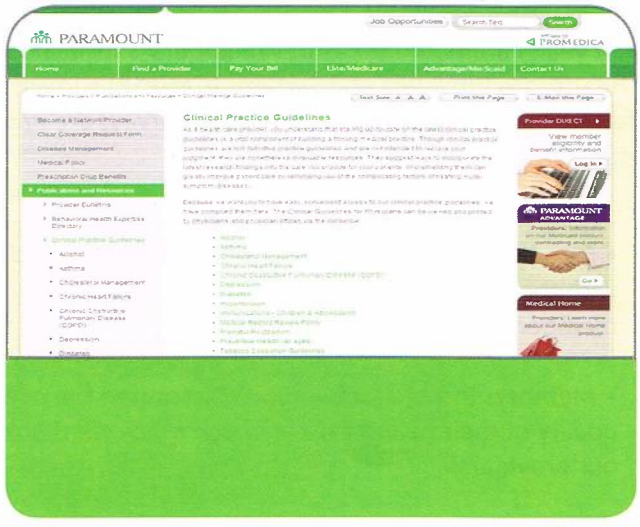




CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

Clinical Practice Guidelines

The Clinical Guidelines for Physicians can be reviewed and printed from the Paramount web site by physicians and physician office staff. These guidelines are evidence-based and intended to be used as a guide in the care of Paramount members. The Medical Advisory Council (MAC) reviews and approves each guideline annually. The guidelines are adopted from various nationally recognized sources, will not cover every clinical situation, and are not intended to replace clinical judgment.



The following guidelines have been reviewed and approved:

- **Adult and Senior Preventive Care Guidelines-** based on U.S. Preventive Services Task Force (USPSTF) and AHRQ Home/Clinical Information/U.S. Preventive Services Task Force recommendations. The guidelines were readopted in December 2017.
- **Pediatric Preventive Care Guidelines-** based on the American Academy of Pediatrics (AAP) 2017 Guidelines. The guidelines were adopted in November 2017.
- **Adult and Pediatric Asthma Guidelines-** based on the "Guidelines for Diagnosis and Management of Asthma," National Asthma Education and Prevention Expert Panel Report III (EPR-3), National Heart, Lung and Blood Institute (NHLBI), 2007. The guidelines were readopted in August 2018.
- **Standards of Medical Care for Patients with Diabetes Mellitus-** based on the American Diabetes Association's 2018 Standards of Medical Care in Diabetes, noteworthy changes are listed on the website. The guidelines were adopted in March 2018.
- **Recommended Childhood Immunization Schedule-** released by the Centers for Disease Control and Prevention (CDC). The Advisory Committee on Immunization Practices (ACIP), the American Academy of Pediatrics (AAP) and the American Family Physicians (AAFP) have endorsed this immunization schedule. The immunization schedule was adopted in April 2017.
- **Cholesterol Management Guideline-** follows the ACC/AHA Guideline on the Treatment of Blood Cholesterol to Reduce Atherosclerotic Cardiovascular Risk in Adults. This guidline was readopted May 2018.
- **Hypertension Guideline-** follows the *Guideline for the Prevention, Detection, Evaluation, and Management of High Blood Pressure in Adults* released by the American College of Cardiology (ACC), the American Heart Association (AHA), American Academy of Physician Assistants (AAPA), Association of Black Cardiologists (ABC), American College of Preventive Medicine (ACPM), American Geriatrics Society (AGS), American Pharmacists Association (APhA), American Society of Hypertension (ASH), American Society for Preventive Cardiology (ASPC), National Medical Association (NMA) and Preventive Cardiovascular Nurses Association (PCNA). Paramount's Medical Advisory Council (MAC) adopted this guideline February 2018.

- **Prenatal and Postpartum Care Guidelines-** based on "Guidelines for Perinatal Care," 8th Ed, American College of Obstetricians & Gynecology (ACOG) and AAP, Revised October 2012. The guidelines were readopted November 2017 with changes.

- **Chronic Obstructive Pulmonary Disease Guideline-** based on the Global Strategy for the Diagnosis, Management, and Prevention of Chronic Obstructive Pulmonary Disease (GOLD). The 2018 GOLD Report contains slight revisions of the GOLD 2017 Report. The 2018 report has been updated to include key peer-reviewed research publications from January 2016 to July 2017, systematic literature searches, and a double blind review by the GOLD Science committee. This guideline was adopted October 2018.

- **Depression Guideline-** based on the USPSTF Screening Guidelines "Screening for Depression in Adults, U.S. Preventive Services Task Force Recommendation Statement, January 2016", "Screening for Depression in Children and Adolescents Recommendation Statement, U.S. Preventive Services Task Force, February 2016", and ProMedica's Clinical Practice Guidelines for Depression. This guideline was adopted September 2017.

- **Heart Failure Guideline-** follows the 2017 ACC/AHA/HFSA Focused Update of the 2013 ACCF/AHA Guideline for the Management of Heart Failure: A Report of the American College of Cardiology/American Heart Association Task Force on Clinical Practice Guidelines and the Heart Failure Society of America. The Medical Advisory Council readopted this guideline October 2018.

- **Alcohol Guideline** - based on the National Institute on Alcohol Abuse and Alcoholism (NIAAA) publications "A Clinician's Guide: Helping Patients Who Drink Too Much," 2005 and "Pocket Guide for Alcohol Screening and Brief Intervention," 2007 remain unchanged. "Alcohol Screening and Brief Intervention for Youth: Practitioner's Guide," 2011 and "Pocket Guide for Alcohol Screening and Brief Intervention for Youth," was revised October 2015. The guideline was readopted in September 2017.

- **Healthchek Guidelines-** based on the Ohio Department of Medicaid (ODM) Healthchek Guidelines for the Paramount Advantage (Medicaid) population. These guidelines were readopted November 2017.

- The **Tobacco Cessation Guidelines-** based on the US Preventive Services Task Force (USPSTF). The Adult Tobacco Cessation Guideline is based on the US Preventive Services Task Force (USPSTF) Recommendations 2015 update. Tobacco Smoking Cessation in Adults, Including Pregnant Women and Tobacco Use in Children and Adolescents Guidelines. Readopted November 2018.

To view these guidelines, go to www.paramountheallthcare.com, click on "Provider," then click on "Publications and Resources" then "Clinical Practice Guidelines."

Paramount's Quality Improvement Program

Paramount's philosophy is that quality improvement is the duty of every employee and contracted provider. We are committed to using a continuous quality improvement cycle in managing both clinical and administrative services and measuring performance indicators across all products. A summary of our Quality Improvement Program and Annual Quality Reports highlighting quality activities and performance on key indicators can be found at http://www.paramounthealthcare.com/quality-program-and-reports. For further information about the Paramount Quality Improvement Program, contact the Quality Hotline at 419-887-2537, Member Services at 1-800-462-3589 (TTY 1-888-740-5670), or e-mail us at PHC.Quality@ProMedica.org.

Prenatal to Cradle Pregnancy Care Reward Program

PRENATAL TO CRADLE (PTC) is a Pregnancy Care Reward program for Paramount Advantage members who are pregnant or have delivered in the last 60 days. Members who are registered for the program are eligible to earn a $25 gift card for each trimester of their pregnancy, if they complete a recommended number of perinatal care appointments, and a $50 gift card for a postpartum visit 21-56 days (3-8 weeks) after delivery (up to $125 in total gift cards).

Paramount Advantage members may be registered online at www.ParamountAdvantage.org by your medical staff, the member, or outreach and care staff. All registrants will also be entered one time into a monthly diaper drawing for the chance to win a 4-week supply of diapers. Three diaper winners are selected each month, one winner in each of our three statewide regions.

The program is marketed statewide through medical providers, FQHCs, community clinics, WIC, JFS, health departments, on-hold messaging, health fairs, and new member packet mailings. In addition, members are identified and enrolled via UCM, transportation requests, QI Health Educators, Member Services, and Pregnancy Risk Assessments. Enrollment in this program is voluntary, but members must be enrolled with Paramount Advantage during their pregnancy and/or postpartum to qualify for gift cards.

Brochures and more information are available by contacting your Paramount Advantage Provider Relations Representative.

Frequently Asked Questions:

How are Paramount Advantage Members Enrolled into the Program?
Members can enroll, or be enrolled, at www.ParamountAdvantage.org. Only their Paramount Advantage Member ID, Name, and LMP are required.

What if a member enrolls later in their pregnancy or is not an Advantage member at the start of their pregnancy?
The program is retroactive to the date they become a Paramount Advantage member or their LMP, whichever is earlier. The program is divided into 3-trimester and 1- postpartum segments; therefore, members becoming effective with Paramount Advantage later in their pregnancy are still eligible to earn at least a portion of the gift cards.

Members with Paramount Advantage as a secondary insurance also qualify.
It is best for members to be enrolled as soon as you know they are pregnant, to allow the program to assist you in keeping the member compliant with their prenatal and postpartum visits.

Please Note:

- Only prenatal/postnatal claims billed to Paramount Advantage are counted toward the program requirements.
- Postpartum claims for visits occurring 21-56 days after delivery should always be billed to Paramount Advantage.
- Please include the appropriate code for weeks of pregnancy in billing.

Paramount Advantage Member Rights and Responsibilities

Members Have the Right To:

- Receive all services that Paramount Advantage must provide.
- Be treated with respect and with regard for their dignity and privacy.
- Be sure that their medical record information will be kept private.
- Be given information about their health. Such information may also be available to someone who they have legally authorized to have the information or whom they said should be reached in an emergency when it is not in the best interest of their health to give it to them.
- Be able to take part in decisions about their healthcare unless it is not in their best interest.
- Recieve information on any medical care treatment, in a way that they can follow.
- Be sure that others cannot hear or see them when they are getting medical care.
- Be free from any form of restraint or seclusion used as a means of force, discipline, ease, or revenge as specified in Federal regulations.
- Ask and get a copy of their medical records, and be able to ask that their record be changed/corrected if needed.
- Be able to say yes or no to having any information about them given out unless Paramount Advantage has to by law.
- Be able to say no to treatment or therapy. If they say no, the doctor or Paramount Advantage must talk to them about what could happen, and they must put a note in their medical record about it.
- Be able to file an appeal, a grievance (complaint), or a state hearing about Paramount Advantage, the doctors or the care they received.
- Be able to get all written member information from Paramount Advantage:
  - at no cost to the member,
  - in the prevalent non-English languages of members in the Paramount Advantage service area,
  - in other ways to help with the special needs of members who may have trouble reading the information for any reason.
- Be able to get help free of charge from Paramount Advantage and its providers if they do not speak English or need help understanding information.
- Be able to get help with sign language if they are hearing impaired.
- Be told if the health care provider is a student and to be able to refuse his/her care.
- Be told of any experimental care and to be able to refuse to be part of the care.
- Make advance directives (a living will).
- File any complaint about not following their advance directive with the Ohio Department of Health.
- Change their Primary Care Provider (PCP) to another PCP on Paramount Advantage's panel at least monthly. Paramount Advantage must send them something in writing that says who the new PCP is and the date the change began.
- Be free to carry out their rights and know that Paramount Advantage and its participating providers or ODM will not hold this against them.
- Know that the Paramount Advantage must follow all federal and state laws, and other laws about privacy that apply.
- Choose the provider that gives you care whenever possible and appropriate.
- Be able to go to a woman's health provider on Paramount Advantage's panel for covered women's health services, if female.
- Be able to get a second opinion from a qualified provider on the Paramount Advantage panel. If a qualified provider is not able to see them, Paramount Advantage must set up a visit with a provider not on the panel.
- Get information about Paramount Advantage from Paramount Health Care.
- Contact the United States Department of Health and Human Services Office of Civil Rights and/or the Ohio Department of Job and Family Services Bureau of Civil Rights at the addresses below with any complaint of discrimination based on race, color, religion, sex, sexual orientation, age, disability, national origin, veteran's status,

ancestry, health status or need for health services.

Office of Civil Rights
United States Department of Health and Human Services
233 N. Michigan Ave, Suite 240
Chicago, Illinois 60601
312-886-2359
TDD: 312-353-5693

Bureau of Civil Rights
Ohio Department of Job and Family Services
30 East Broad Street, 37th Floor
Columbus, Ohio 43215
614-644-2703
1-866-227-6353
TTY: 1-866-221-6700

In addition to the rights listed above, Paramount Advantage members also have the right to:

- Receive information about Paramount Advantage , its services, providers, and members' rights and responsibilities.
- Be treated with respect and recognition of their dignity and need for privacy.
- Participate with providers in decision making regarding their health care.
- A candid discussion of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage.
- Voice complaints or appeals about the managed care organizations or the care provided.
- Receive equal and fair treatment (the quality of treatment that other patients receive).
- Continue as a member of Paramount Advantage regardless of their health status or need for care.
- Receive their ID cards and Member Handbooks in a timely manner.
- Add new eligible dependents to their coverage
- Seek treatment for an Emergency Medical Condition without contacting their PCP. ["Emergency Medical Condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following: placing the health of the individual (or, with respect to a pregnant woman or her unborn child) in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of an bodily organ or part.]
- Call the Member Service Department twenty-four (24) hours a day at 419-887-2525 or toll free at 1-800-462-3589.
- A right to make recommendations regarding Paramount Advantage's member rights and responsibilities policies.

Members Have Responsibility To:

- Provide, to the extent possible, information that Paramount Advantage and the participating providers need to care for them. Help their PCP fill out current medical records by providing current prescriptions and their previous medical records.
- Engage in a healthy lifestyle, become involved in their health care and follow the plans and instructions for the care that they have agreed upon with their PCP or specialists.
- Treat their Primary Care Provider (PCP) with respect and dignity.
- Inform their PCP of any symptoms and problems and to ask questions.
- Obtain information and consider the information about any treatment or procedure before it is done. Discuss any problems in following the recommended treatment with their PCP.
- Respect the privacy of other patients in the office.

- Members are encouraged to inform their PCP, or the doctor or facility taking their calls, before seeing a consultant/specialist. The only times they do not need to contact their PCP to see a consultant/specialist are for appointments with obstetricians, gynecologists, certified nurse practitioners, certified nurse-midwives, qualified family planning providers, OMA and community mental health Medicaid providers, federally qualified health center providers and vision and dental providers (routine care only).
- Continue seeing their previous PCP until the transfer takes effect.
- Continue following Paramount Advantage policies and procedures until disenrollment takes effect.
- Schedule and keep appointments and be on time. Always call if they need to cancel an appointment or if they will be late.
- Learn and follow policies and procedures as outlined in the handbook.
- Indicate to their doctor who they wish to designate to receive information regarding their health.
- Obtain medical services from their PCP.
- Treat all providers and her/his staff politely and courteously with respect and dignity. Providers include but are not limited to: PCPs; professional, medical, pharmacy, dental, vision, hearing, chiropractic, alternative medicine, transportation assistance, ProMedica and Paramount employees, interpreters, etc.
- Become involved in their health care and cooperate with their PCP regarding recommended treatment.
- Carry their ID card at all times and report any lost or stolen cards to Paramount Advantage immediately. Also, contact Paramount Advantage if any information on the card is incorrect, or if there are changes in name, address or eligibility.
- Inform Paramount Advantage of any dependent that is to be added or removed from coverage.
- Notify their PCP as soon as possible if they have received emergency treatment with forty-eight (48) hours.
- Call the Member Service Department if they have a problem and need assistance.

Paramount Commercial Member Rights and Responsibilities - Ohio & Michigan

PURPOSE: To provide subscribers of Paramount commercial of the product with information regarding their individual rights and responsibilities pertaining to participation in their chosen health plan.

DEFINITION: Member Rights and Responsibilities are defined as those privileges and obligations extended to subscribers participating in Paramount.

POLICY: It is the policy for Paramount to provide written documentation regarding Member Rights and Responsibilities as contained in the Member Handbook. The Member Rights and Responsibilities are as follows:

Member Rights

All Members have the right to:

1. Receive information about Paramount, its services, practitioners and providers, and their rights and responsibilities.
2. Participate with their physicians in decision making regarding their health care.
3. A candid discussion of appropriate or medically necessary treatment options for the conditions regardless of cost or benefit coverage.
4. Be treated with respect, recognition of their dignity and the need for privacy.
5. Make recommendations regarding the organization's member rights and responsibilities policies.
6. Voice complaints or appeals about the health plan or care provided.

Member Responsibilities

All Members have the responsibility to:

1. Provide, to the extent possible, information that Paramount and participating practitioners and providers need in order to care for them.
2. Engage in a healthy lifestyle, become involved in their health care and follow the plans and instructions for the care that they have agreed on with their PCP or specialists.
3. To understand their health problems and participate in developing mutually agreed-upon treatment and goals to the degree possible.

Patient Rights and Responsibilities

Michigan law sets forth the following rights and responsibilities for health care patients:

1. A patient or resident is responsible for following the health facility rules and regulations affecting patient or resident care and conduct.
2. A patient or resident is responsible for providing a complete and accurate medical history.
3. A patient or resident is responsible for making it known whether he or she clearly comprehends a contemplated course of action and the things he or she is expected to do.
4. A patient or resident is responsible for following the recommendations and advice prescribed in a course of treatment by the physician.
5. A patient or resident is responsible for providing information about unexpected complications that arise in an expected course of treatment.
6. A patient or resident is responsible for being considerate of the rights of other patients or residents and health facility personnel and property.
7. A patient or resident is responsible for providing the health facility with accurate and timely information concerning his or her sources of payment and ability to meet financial obligations.

Paramount Elite Member Rights and Responsibilities

Section 1.4 We must protect the privacy of your personal health information

Federal and state laws protect the privacy of your medical records and personal health information. We protect your personal health information as required by these laws.

- Your "personal health information" includes the personal information you gave us when you enrolled in this plan as well as your medical records and other medical and health information.
- The laws that protect your privacy give you rights related to getting information and controlling how your health information is used. We give you a written notice, called a "Notice of Privacy Practice," that tells about these rights and explains how we protect the privacy of your health information.

How do we protect the privacy of your health information?

- We make sure that unauthorized people don't see or change your records.
- In most situations, if we give your health information to anyone who isn't providing your care or paying for your care, *we are required to get written permission from you first*. Written permission can be given by you or by someone you have given legal power to make decisions for you.
- There are certain exceptions that do not require us to get your written permission first. These exceptions are allowed or required by law.
- For example, we are required to release health information to government agencies that are checking on quality of care.
- Because you are a member of our plan through Medicare, we are required to give Medicare your health information including information about your Part D prescription drugs. If Medicare releases your information for research or other uses, this will be done according to Federal statutes and regulations.

You can see the information in your records and know how it has been shared with others

You have the right to look at your medical records held at the plan, and to get a copy of your records. We are allowed to charge you a fee for making copies. You also have the right to ask us to make additions or corrections to your medical records. If you ask us to do this, we will work with your health care provider to decide whether the changes should be made. You have the right to know how your health information has been shared with others for any purposes that are not routine. If you have questions or concerns about the privacy of your personal health information, please call Member Services (phone numbers are printed on the back cover of this booklet).

Section 1.5 We must give you information about the plan, its network of providers, and your covered services

As a member of Paramount Elite, you have the right to get several kinds of information from us. (As explained above in Section 1.1, you have the right to get information from us in a way that works for you. This includes getting the information in languages other than English and in large print or other alternate formats.) If you want any of the following kinds of information, please call Member Services (phone numbers are printed on the back cover of this booklet):

- **Information about our plan.** This includes, for example, information about the plan's financial condition. It also includes information about the number of appeals made by members and the plan's performance ratings, including how it has been rated by plan members and how it compares to other Medicare health plans.

- **Information about our network providers including our network pharmacies.**
- For example, you have the right to get information from us about the qualifications of the providers and pharmacies in our network and how we pay the providers in our network.
- For a list of the providers in the plan's network, see the Paramount Elite *Provider Directory*.
- For a list of the pharmacies in the plan's network, see the Paramount Elite *Pharmacy Directory*.
- For more detailed information about our providers or pharmacies, you can call Member Services (phone numbers are printed on the back cover of this booklet) or visit our website at http://www.paramounthealthcare.com/medicareplans.

- **Information about your coverage and the rules you must follow when using your coverage.**
- In Chapters 3 and 4 of this booklet, we explain what medical services are covered for you, any restrictions to your coverage, and what rules you must follow to get your covered medical services.
- To get the details on your Part D prescription drug coverage, see Chapters 5 and 6 of this booklet plus the plan's *List of Covered Drugs (Formulary)*. These chapters, together with the *List of Covered Drugs (Formulary)*, tell you what drugs are covered and explain the rules you must follow and the restrictions to your coverage for certain drugs.
- If you have questions about the rules or restrictions, please call Member Services (phone numbers are printed on the back cover of this booklet).

Information about why something is not covered and what you can do about it.

- If a medical service or Part D drug is not covered for you, or if your coverage is restricted in some way, you can ask us for a written explanation. You have the right to this explanation even if you received the medical service or drug from an out-of-network provider or pharmacy.
- If you are not happy or if you disagree with a decision we make about what medical care or Part D drug is covered for you, you have the right to ask us to change the decision. You can ask us to change the decision by making an appeal. For details on what to do if something is not covered for you in the way you think it should be covered, see Chapter 9 of this booklet. It gives you the details about how to make an appeal if you want us to change our decision. (Chapter 9 also tells about how to make a complaint about quality of care, waiting times, and other concerns.)
- If you want to ask our plan to pay our share of a bill you have received for medical care or a Part D prescription drug, see Chapter 7 of this booklet.

Section 1.6 We must support your right to make decisions about your care

You have the right to know your treatment options and participate in decisions about your health care.
You have the right to get full information from your doctors and other health care providers when you go for medical care. Your providers must explain your medical condition and your treatment choices *in a way that you can understand.* This means getting the information in a language other than English as spoken by a qualified interpreter or in sign language with no cost to you. (Also see Section 1.1 of this booklet.) You may call Member Services before an appointment for help to arrange interpreter assistance (phone numbers are printed on the back cover of this booklet). If you are asked to sign any forms or papers that you do not understand, you may ask for it to be read to you out loud in English or by a qualified interpreter.

You also have the right to participate fully in decisions about your health care. To help you make decisions with your doctors about what treatment is best for you, your rights include the following:

- **To know about all of your choices.** This means that you have the right to be told about all of the treatment options that are recommended for your condition, no matter what they cost or whether they are covered by our plan. Our plan does not restrict dialogue between practitioners and patients, nor do we direct practitioners to restrict information regarding your treatment options. It also includes being told about programs our plan offers to help members manage their medications and use drugs safely. It also includes being told about programs our plan offers to help members manage their medications and use drugs safely.

- **To know about the risks.** You have the right to be told about any risks involved in your care. You must be told in advance if any proposed medical care or treatment is part of a research experiment. You always have the choice to refuse any experimental treatments.

- **The right to say "no."** You have the right to refuse any recommended treatment. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to leave. You also have the right to stop taking your medication. Of course, if you refuse treatment or stop taking medication, you accept full responsibility for what happens to your body as a result.

- **To receive an explanation if you are denied coverage for care.** You have the right to receive an explanation from us if a provider has denied care that you believe you should receive. To receive this explanation, you will need to ask us for a coverage decision. Chapter 9 of this booklet tells how to ask the plan for a coverage decision.

You have the right to give instructions about what is to be done if you are not able to make medical decisions for yourself.

Sometimes people become unable to make health care decisions for themselves due to accidents or serious illness. You have the right to say what you want to happen if you are in this situation. This means that, *if you want to*, you can:

- Fill out a written form to **give someone the legal authority to make medical decisions for you** if you ever become unable to make decisions for yourself.
- **Give your doctors written instructions** about how you want them to handle your medical care if you become unable to make decisions for yourself. The legal documents that you can use to give your directions in advance in these situations are called **"advance directives."** There are different types of advance directives and different names for them. Documents called **"living will"** and **"power of attorney for health care"** are examples of advance directives. If you want to use an "advance directive" to give your instructions, here is what to do:
- **Get the form.** If you want to have an advance directive, you can get a form from your lawyer, from a social worker, or from some office supply stores. You can sometimes get advance directive forms from organizations that give people information about Medicare.
- **Fill it out and sign it.** Regardless of where you get this form, keep in mind that it is a legal document. You should consider having a lawyer help you prepare it.
- **Give copies to appropriate people.** You should give a copy of the form to your doctor and to the person you name on the form as the one to make decisions for you if you can't. You may want to give copies to close friends or family members as well. Be sure to keep a copy at home.

If you know ahead of time that you are going to be hospitalized, and you have signed an advance directive, **take a copy with you to the hospital**.

- If you are admitted to the hospital, they will ask you whether you have signed an advance directive form and whether you have it with you.
- If you have not signed an advance directive form, the hospital has forms available and will ask if you want to sign one.

Remember, it is your choice whether you want to fill out an advance directive (including whether you want to sign one if you are in the hospital). According to law, no one can deny you care or discriminate against you based on whether or not you have signed an advance directive.

What if your instructions are not followed?

If you have signed an advance directive, and you believe that a doctor or hospital did not follow the instructions in it, you may file a complaint with your State Department of Health. **Ohio residents** may file a complaint with the Ohio Department of Health at 614-466-3543. **Michigan residents** may file a complaint with the Michigan Attorney General at 1-877-765-8388. Your "power of attorney for health care" or other legally authorized person may file this complaint if you are unable to do so. You also have the right to make this complaint with us by calling Member Services (phone numbers are printed on the back cover of this booklet).

Section 1.7 You have the right to make complaints and to ask us to reconsider decisions we have made.

If you have any problems or concerns about your covered services or care, Chapter 9 of this booklet tells what you can do. It gives the details about how to deal with all types of problems and complaints. What you need to do to follow up on a problem or concern depends on the situation. You might need to ask our plan to make a coverage decision for you, make an appeal to us to change a coverage decision, or make a complaint. Whatever you do – ask for a coverage decision, make an appeal, or make a complaint – **we are required to treat you fairly**. You have the right to get a summary of information about the appeals and complaints that other members have filed against our plan in the past. To get this information, please call Member Services (phone numbers are printed on the back cover of this booklet).

Section 1.8

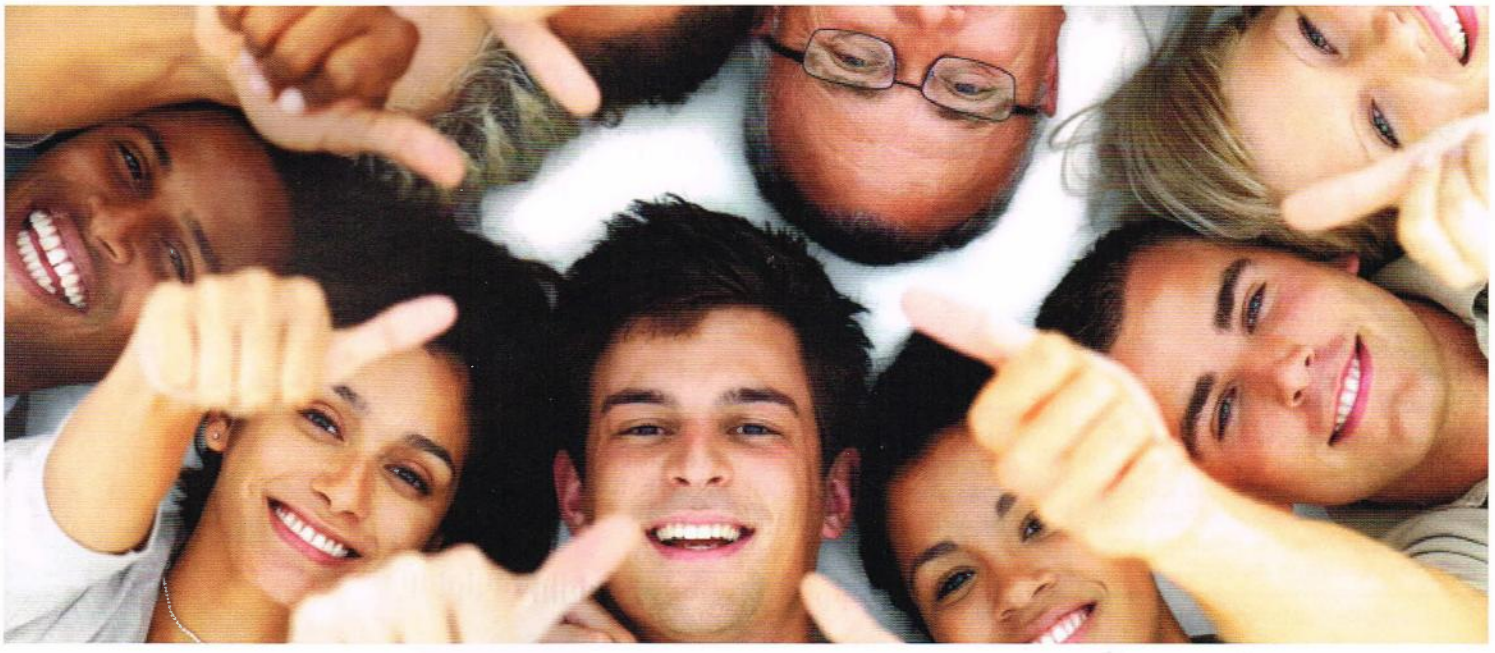
What can you do if you believe you are being treated unfairly or your rights are not being respected?
If it is about discrimination, call the Office for Civil Rights.
If you believe you have been treated unfairly or your rights have not been respected due to your race, disability, religion, sex, health, ethnicity, creed (beliefs), age, or national origin, you should call the Department of Health and Human Services' **Office for Civil Rights** at 1-800-368-1019 or TTY 1-800-537-7697, or call your local Office for Civil Rights.

Is it about something else?
If you believe you have been treated unfairly or your rights have not been respected, *and* it's *not* about discrimination, you can get help dealing with the problem you are having:

- You can **call Member Services** (phone numbers are printed on the back cover of this booklet).
- You can **call the State Health Insurance Assistance Program**. For details about this organization and how to contact it, go to Chapter 2, Section 3.
- Or, **you can call Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Section 1.9 How to get more information about your rights
There are several places where you can get more information about your rights:

- You can **call Member Services** (phone numbers are printed on the back cover of this booklet).
- You can **call the SHIP**. For details about this organization and how to contact it, go to Chapter 2, Section 3.
- You can contact **Medicare**.
- You can visit the Medicare website to read or download the publication "Your Medicare Rights & Protections." (The publication is available at: http://www.medicare.gov/Pubs/pdf/11534.pdf.)
- Or, you can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.



HMO Individual Exchange Member Rights and Responsibilities

Member Rights

As a Member of Paramount, you have certain rights you can expect from Paramount and Paramount providers. You have the right to:

1. Receive information about Paramount, its services, providers and your rights and responsibilities.
2. Participate with your physicians in decision-making regarding your health care.
3. A candid discussion of appropriate or Medically Necessary treatment options for the conditions regardless of cost or benefit coverage.
4. Voice complaints or appeals about the Health Plan or care provided.
5. Be treated with respect, recognition of your dignity and the need for privacy.
6. Make recommendations regarding Paramount's Member rights and responsibilities policies.

Member Responsibilities

As a Member of Paramount, you have certain responsibilities that Paramount and Paramount providers can expect from you. You have the responsibility to:

1. Provide to the extent possible information that Paramount and the Participating Providers need to care for you. Help your PCP fill out current medical records by providing current prescriptions and your previous medical records.
2. Engage in a healthy lifestyle, become involved in your health care and follow the plans and instructions for the care that you have agreed on with your PCP or specialists.
3. Understand your health problems and participate in developing mutually agreed-upon treatment and goals to the degree possible.

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PARAMOUNT

Affiliate of ProMedica

NETWORKNEWS
Provided as a service to our Provider and Office Manager Community

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Communicating with the physician and his or her office staff is very important to Paramount. This newsletter will be published semi-annually, with emphasis on topics that relate to physician and staff participation in the plan.

PHC-NN-Fall18/Winter19

Did you know?

Paramount provides transportation for Advantage Members.
To schedule rides, members can contact Transportation Scheduling & Pick-up at 1-866-837-9817 (TTY users 1-800-750-0750)
Monday - Friday 7:00 a.m. - 7:00 p.m.

Questions & Concerns - call Member Services at 1-800-462-3589 (TTY 1-888-740-5670).

Screen for Microalbuminuria in Patients with Diabetes

Why?

- To identify patients with diabetic kidney disease (DKD).
- To distinguish DKD patients from diabetic patients with chronic kidney disease (CKD) from other causes. The latter requires further investigation and possibly different clinical management.
- To detect early stages of CKD, markers of kidney damage are required. Estimated glomerular filtration rate (eGFR) alone can only detect CKD stage 3 or worse.
- To ensure regulatory compliance. Paramount's regulatory bodies (National Committee for Quality Assurance (NCQA) through HEDIS measures, and Ohio Department of Medicaid (ODM) **do not** recognize eGFR's as a valid screening tool for nephropathy screening in the diabetic population.

How to test for Microalbuminuria?

- **Paramount asks all providers to use accepted (NCQA/ODM) methods:**
  - ✓ 24-hour urine for albumin or protein.
  - ✓ Timed urine for albumin or protein.
  - ✓ Spot urine (e.g., urine dipstick or test strip) for albumin or protein.
  - ✓ Urine for albumin/creatinine ratio.
  - ✓ 24-hour urine for total protein.
  - ✓ Random urine for protein/creatinine ratio.

Paramount thanks all providers for helping us improve the quality of life for our members!